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ABSTRACT

People who suffer from body dysmorphic disorder believe that their body is defected and that this defect makes them ugly. Their distorted body image can be precipitated by many internal and external factors and as a result of their imagined defect, these normal-appearing individuals exhibit self-defeating behaviors. The disorder can lead to the development of various other disorders, including depression, obsessive-compulsive behavior, mood disorders, and avoidant personality disorders among others. If counselors are to diminish the symptoms of body dysmorphic disorder, the disorder must first be thoroughly understood. Variations of cognitive therapies can help individuals with body dysmorphic disorder to address their irrational thoughts and thus enable them to become more accepting of themselves. Antidepressants are frequently employed, as is reflective therapy where patients explore past feelings about their body image during major developmental periods. Although subjects with this disorder view themselves in an irrational light, the patient must accept his or her body as normal before recovery can be effected. Sufferers can replace negative beliefs with positive ones and develop a new self-assurance and a sense of well-being. (RJM)

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Body Dysmorphic Disorder

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Body Dysmorphic Disorder:
Easing the Distress of Distortion
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Running head: BODY DYSMORPHIC DISORDER

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Abstract

Body dysmorphic disorder is a disorder in which an imagined defect in appearance gives individuals a subjective feeling of ugliness. Their distorted body image can be precipitated by many internal and external factors. As a result of their imagined defect, these normal-appearing individuals exhibit self-defeating behaviors. This disorder can lead to the development of various other disorders. Variations of cognitive therapies can help an individuals with body dysmorphic disorder to address their irrational thoughts and enable them to become more accepting of themselves.

Placing a great deal of emphasis on one's appearance is, more often than not, considered superficial. However, one's aesthetic qualities, or lack thereof, can have an overwhelming impact on the way in which one perceives oneself. The opinions that an individual holds concerning his or her appearance can either promote productive or self-defeating behaviors.

If a physical anomaly is present, a certain degree of self-consciousness is warranted. However, when an individual exhibits a "preoccupation with some imagined defect in appearance in a normal-appearing person" (American Psychiatric Association, 1987, p. 255) in gross excess, there is a cause for concern. In such a case, the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) provides for the possible diagnosis of Body Dysmorphic Disorder.

This disorder was previously called "dysmorphophobia" in reference to an individual's subjective feeling of ugliness due to a fundamental delusion of body image or the morbid fear of deformity (Mosby's Medical and Nursing Dictionary, 1986). It was

later changed to Body Dysmorphic Disorder since the fear of upsetting others with their ugliness does not involve a phobic avoidance.

An individual with body dysmorphic disorder feels extremely ashamed of and embarrassed by his or her "defect". Consequently, he or she avoids "usual social or occupational activities such as working, shopping, swimming, attending school and gym class, dating and sex to the point of being house-bound" (Phillips, McElroy, Keck, Pope, & Hudson, 1993, p. 304).

Their social withdrawal and isolation is not the only damaging effect of this disorder. Individuals with body dysmorphic disorder also repeatedly visit health professionals such as plastic surgeons, dermatologists, and dentists in a desperate hope that they will "fix" their problem. If they enter plastic surgery (such as rhinoplasty) with "realistic expectations" (Sharp, 1991, p. 30), then their self-image may in fact be enhanced. However, many plastic surgeons are sensitive enough to pick up on these persistent individuals, since the physicians are able to see that a real physical problem does not exist. This is usually when a mental health professional is

notified.

It is important to take into consideration that this is not an intentional disorder that the individual can consciously control. For them, the defect is very real and it causes the individual much anxiety.

With body dysmorphic disorder, many other factors must also be taken into consideration. For example, the person is exhibiting a body-image problem, as well as psychosocial distress. Also, those who suffer from body dysmorphic disorder are often found to have a high comorbidity rate with other disorders in the DSM-III-R (Phillips, 1991).

Many forms of treatment may prove to be successful for individuals with body dysmorphic disorder. Cognitive therapy in conjunction with serotonin reuptake-blocking antidepressants may be the most beneficial form of treatment. Cognitive therapy may enable them to "dispute their irrational beliefs and may be helpful in overcoming [their] disturbed body-image and related negative self-concept" (Dworkin & Kerr, 1987, p. 136).

The Role of Body Image

An increasing awareness of one's appearance

becomes apparent as puberty transpires. Folk, Petersen, and Cullari (1993) emphasize "that the linkage between self-concept and body satisfaction is not necessarily brought on by pubertal development but rather because of the social importance [which becomes more obvious at this time that is] placed on the 'perfect body'" (p. 552). If one is comfortable with the way in which he or she looks, a healthy self-concept of a positive nature will develop. Conversely, if one is dissatisfied with his or her body-image, self-esteem may be hindered. Consequently, a preoccupation with an actual or imaged "flaw" may evolve if one is unable to accept an aspect of one's physique.

While children are taught at an early age to pay no attention to what others have to say if it is not nice, they take to heart the harsh words that have been spoken. The emotional ramifications of persistent teasing can be devastating and long-term. According to Gray (1997), "it is not unusual for individuals to experience heightened stress in response to other's perceptions of their bodies" (Spink, 1992, p. 1075).

The humiliating comments may disappear down the

line, but as a result the child may develop a preoccupation with the "shortcoming" that normal development allowed them to outgrow. So while the object of criticism no longer exists physically, it still may be very apparent and real for the individual. The reactions of other's can affect a persons self-esteem to a large degree. When one is self-conscious, the effects of name calling can have an even harder impact. On the other hand, even if others are accepting of a child, he or she may be overly critical in relation to his or her own appearance. In this respect, the self-conscious emotions that grow are internally manifested. One may feel that he or she possesses "a bumpy nose, a crooked lip, an egg-head, or thinning hair...inadequately firm eyes, atrophied facial muscles, or an ugly face" (Phillips, McElroy, Keck, Pope, & Hudson, 1993, p. 303), and one woman even went so far as to slash her breasts because she thought they were ugly.

Do these distortions indicate that the individual possesses a problem with mental imagery, making it difficult to maintain an accurate picture of themselves? Or rather, is their body-image distortion

"the result of a judgement bias that individuals impose in evaluating their bodies?" (Auchus, Kose, & Allen, 1993, p. 719). In individuals with body dysmorphic disorder, it may in fact be a combination of both faulty mental imagery and too rigid a bias against themselves that they are unable to break free from on their own.

Body-image "distortion", according to Jasper and Maddocks (1992), "refers to a significant discrepancy between one's own perception of, or beliefs about, the size of one's body and its actual size and shape" (p. 183). When severe discrepancies exist, as with individuals who manifest body dysmorphic disorder, the self-esteem and the self-concept of the individual are bound to suffer. On the same note, their low self-esteem and low self-concept may in return magnify the distortion.

These distortions lead the individual with body dysmorphic disorder to acquire a negative body-image. Not surprisingly, Archer and Cash (1985) "found that subjects with negative body-images showed significantly more social introversion" (Theron, Nel, & Lubbe, 1991, p. 979). In essence, they fear ridicule. Since they

are afraid that others will stare or laugh at them, they retreat inward. Hence, the individual develops a social anxiety.

In the home of individuals with body dysmorphic disorder, mirrors and other reflective surfaces can play a significant role. He or she may spend up to four hours each day examining their defect or trying to camouflage it, while others may avoid reflective surfaces at all costs (Phillips, McElroy, Keck, Pope, & Hudson, 1993). Both behaviors, excessive looking and avoidance, are attempts made by the individual to minimize the anxiety that they have manifested over their imagined defect.

Comorbidity With Other Disorders

The existence of body dysmorphic disorder is seen as a disorder in and of itself. This disorder is usually brought to a mental health professionals attention due to a referral from a plastic surgeon or the individual commits to therapy with a non-related "presenting problem". Body dysmorphic disorder is generally present in conjunction with one of several other disorders described in the DSM-III-R.

Phillips's (1991) research led her to conclude

that "the most commonly associated psychiatric disorder appears to be depression" (p. 1138). The individual's depression, most research implies, is precipitated by his or her preoccupation with the said defect: not vise-versa.

Another disorder commonly associated with body dysmorphic disorder is the obsessive-compulsive disorder. For instance, the person is obsessed with the thought of their defect and compulsive mirror checking is the resulting behavior. It is important to note that the imagined defect brings about the obsessive-compulsive behavior. Phillips, McElroy, Keck, Pope, and Hudson (1993) had an interesting observation: "several patients with both body dysmorphic disorder and obsessive-compulsive disorder stated that the former was more painful, embarrassing, emotionally distressing, and socially impairing than the latter" (p. 304).

In addition to depression and obsessive-compulsive behavior, mood disorders, avoidant personality disorders, schizophrenia, monosymptomatic hypochondriasis, anorexia nervosa, and severe neurosis can all serve as symptoms to body dysmorphic disorder

(Phillips, 1991). A thought provoking case was reported by von Zauner (1979) in which "anorexia nervosa was secondary to the body dysmorphic disorder: the patient starved himself because he feared his cheeks were 'too rosy and round'" (Phillips, 1991, p. 1142).

Treatment

As evidenced above, severe problems in one's body-image can be very distressing. If the counselor is to diminish the symptoms of a particular disorder, the disorder must first be thoroughly understood. Brouwers (1990) feels that in order to be effective it is of the utmost importance for the counselor to believe and to communicate to the client that feelings towards one's body-image can change.

Many treatments have been proven to be therapeutically effective in dealing with body dysmorphic disorder. As mentioned previously, cognitive therapy is the most successful technique for directly attacking the distorted belief, forcing an analysis, and allowing for an evaluation and eventual change of beliefs. Dworkin and Kerr (1987) stress that because the client may not view his or her thoughts as

being irrational, the timing of cognitive work on body-image dissatisfaction must be sensitively approached. This will diminish the possibility that the client may feel that the counselor simply does not understand.

Cognitive therapy focuses on altering irrational, negative beliefs and replacing them with more positive ones. Homework in this type of therapy is often assigned: daily, the client must jot "down any automatic thoughts concerning negative body-image; a more rational, positive belief; and any feelings that they had about either the positive or negative beliefs" (Dworkin & Kerr, 1987, p. 137).

Cognitive behavior therapy adds one more step to this process: self-reinforcement for the positive beliefs. In addition, cognitive behavior therapy utilizes a fantasy exercise. In the fantasy exercise, Dworkin and Kerr (1987) explain that the client need only to envision him or herself as a competent, confident person with an acceptable body. In this fantasy, the imagined defect does not exist and the individual is able to see him or herself realistically.

In many cases when dealing with individuals with body dysmorphic disorder, it is necessary to use

antidepressants: particularly the serotonin reuptake-blocking ones. While the data clearly displayed that these were almost imperative for effective therapy and the most efficient with this type of disorder, rationale was not provided.

Reflective therapy is another technique used to alter the negative, irrational beliefs and replace them with more positive, rational ones. However, the approach taken by the reflective therapy technique is slightly different. The focus on this type of therapy is on the "exploration of feelings about body-image during major developmental periods of the woman's [or man's] life" (Dworkin & Kerr, 1987, p. 138).

Therapy, in a sense, is centered on feelings. In fact, a journal of feelings is required to be kept as a homework assignment. While it is necessary for cognitive imagery to become undistorted, it is also necessary for the individuals feelings about him or herself to become more positive. This would allow for a lessening of self-consciousness, a boost in self-esteem, and eventually self-acceptance.

While it can be long, hard work trying to normalize one's body-image, this is a precondition for

recovery (Bruch, 1973). An approach that can be used in conjunction with cognitive therapy, cognitive behavior therapy, and reflective therapy towards the normalization of body-image is through the use of video feedback (Vandereycken, Depreitere, & Probst, 1987). This is a very confrontational method in which they are able to observe their physical appearance objectively.

If a secondary disorder was in fact precipitated by the individual's body dysmorphic disorder, this too must be given therapeutic attention.

Discussion

Self-defeating behaviors can result from a severely distorted negative body-image. These behaviors can range from social isolation to unnecessary surgical procedures. Many reasons may account for the preoccupation of an imagined defect. Individuals with body dysmorphic disorder are unable to see themselves rationally. The rigid belief that they have an offensive defect, although it is imagined, can be very distressing and anxiety promoting.

However, there is a way to ease the psychological pain caused by their body-image distortion. Through cognitive therapy and the use of antidepressants, one

is able to counteract negative beliefs and replace them with more positive ones. Thus, they can eventually alter their belief system. While this process is not easy for individuals with body dysmorphic disorder, with the help of an understanding and supportive therapist irrational beliefs can become a little more rational and logical.

In conclusion, normalization of one's body-image is possible. It, of course, involves a lot of hard work. But, the new self-assurance and confidence that a more positive self-concept can promote are well worth the struggle. Fortunately, self-acceptance is possible for individuals with body dysmorphic disorder.

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